Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DARYL PATE DC
6225 FEATHERWIND
FT WORTH TX 76135

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-09-0830-01 (previously M4-08-4697-01)

MFDR Date Received
March 10, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The initial FCE on Wanda Johnson was done 10-04-07 and the EOB denied payment based on extent of injury. A reconsideration letter was set out with the same denial. It should be noted the CCH report has disc injury as injury body part and there is no proof in the file that the carrier disputed this in time. The original DD gave a letter of clarification explaining that we rescinded the IR and MMI due to disc surger after he saw her. Also there was a recent DD report that giver her diagnosis as disc injury and also she had lumbar surgery from this injury. I ask this FCE be paid or proof sent that the disc injury is in dispute."

Amount in Dispute: $200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No information or bills regarding dos 3/10/08. The carrier received the bill for dos 10/4/07 for $200.00 on 10/13/07 and 12/29/07. Both dates were reviewed and denied based on non-covered procedure. There are disputes filed 2/4/07 and 4/3/07 regarding the lumbar and accepted body parts which were filed timely. Attached is also a copy of the decision and order regarding finalization of claimant mmi and 0% rating. Carrier standing on its position that the services rendered 10/4/07 are not related to the compensable injury/body parts accepted for this injury."

Response Submitted by: Ace American Insurance, PO Box 31143, Tampa, FL 33631

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 4, 2007	CPT Code 97750	$200.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 24, 2007 and January 11, 2008:
   - W12 – Extent of injury. No finally adjudicated.
   - (880-125) – Denied per insurance: NC (non-covered) procedure or service. 100%

Issues

1. Did the requestor file this dispute in the form and manner prescribed by the Division?
2. Is the requestor entitled to reimbursement?

Findings

1. According to 28 Texas Administrative Code §133.307(c)(2)(A) the provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills). Review of the submitted documentation reveals that the initial and reconsideration billings were not included in the request for medical fee dispute resolution. Therefore, the requestor has not met the requirement of the rule.
2. Review of the submitted documentation finds that the requestor did not meet the requirements of 28 Texas Administrative Code §133.307(c)(2)(A), as a result reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 28, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.